DRAFT LOC Proposals

FOR REVIEW AND COMMENT

Introduction

In 2001, the General Assembly adopted significant reform legislation to restructure how services to those with mental illnesses, developmental disabilities and substance abuse issues would be delivered. The foundations of reform included: local management of the system, decreased reliance on State institutions, community based best practice treatments, increased consumer involvement, access to multiple and qualified providers, and performance and fiscal accountability to the State and local governments. As part of the legislation, the General Assembly directed the Secretary of DHHS ("Secretary") and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services ("Division") to undertake administering massive system reform. The reform has been overseen by the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC).

The reform effort never assumed that the system was adequately or fairly funded. It did attempt to shift resources from the State to the local level, to target services to those with the most severe disabilities, and to gain administrative efficiencies and economies of scale through consolidation. In 2001, the General Assembly created the Mental Health Trust Fund and made a significant appropriation of $50 million to assist reform. However, reform has taken place during a time of significant budget shortfalls and intervening events have severally diminished both the size of the Trust Fund and the State's ability to make up the shortfalls. As a result, during the five years of implementation, the State has not fully funded existing programs nor provided sufficient funds to build service capacity at the local level. LOC staff has estimated that it would cost $172,585,338 to bring the current level of services to all who are eligible and who would also seek services. This figure does not take into account any increase in the array or availability of services. Other estimates of the State's need range from an additional $475 million to fully fund substance abuse services over 5 years and $285 million to bring North Carolina's per capita spending for mental health services to near the national average.

In recognition of these shortcomings, the LOC makes the findings and recommendations on the following pages. **The total appropriations recommended herein are $155,179,521. Of that, $99.3 million are recurring funds and $55.9 million are non-recurring.**

1. State Funding for MH/DD/SA Services and Funding Allocations

Findings:

The total (state and federal) actual expenditures for FY04/05 for the mental health, developmental disabilities, and substance abuse system (MH/DD/SA) were $1,102,393,603.[1] Of those funds, 52% or $575,965,746 paid for the State institutions and 3% or $36,597,727 paid for administration. The remaining 44% or $489,830,130 was used to pay for community programs.

Of the total funds appropriated by the State, $580,479,364 (or 53%) were state funds. In FY2005, the average State funds expended per person served with a developmental disability were $10,192. The average State funds expended per person served with a mental illness were $1,001. The average State funds expended per person served with a substance abuse diagnosis were $1,028. During FY2005, the State paid a total of $124,951,834 in claims for developmental disability services, $87,037,667 in claims for mental health services, and $28,702,300 for substance abuse services.

According to a report issued by the National Alliance on Mental Illness (NAMI Report Card)[2], North Carolina ranks 43rd among the states in its per capita spending for mental health services. According to a report issued by the North Carolina Psychiatric Association, it would cost an additional $285,500,000 to bring North Carolina's per capita spending on mental health services to 88.8% of the national per capita spending in FY2002-2003.[3]

According to the 2001 report to the LOC by MGT of America[4], the estimated cost of implementing a complete substance abuse system in North Carolina over a 5-year period would require an additional $71,000,000 funding in FY 2003, $74,000,000 for FYs 2004 and 2005, and an additional $127,000,000 in FYs 2006 and 2007.

According to information provided to the LOC by committee staff, the estimated State funds that would be needed to serve the estimated target populations who are not Medicaid eligible and who would seek public services would be $172,585,338.[5] This amount represents what it would cost to serve more consumers based on current State spending per consumer.

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[1] This amount does not include Medicaid funds flowing to the community or directly to providers.
[2] National Alliance on Mental Illness. Grading the States: A Report on America's Health Care system for Serious Mental Illness, published March 1, 2006.
[3] The 88.8% figure represents North Carolina's average income in relationship to the national average income.
[4] MGT of America. Study of Mental Health/Substance Abuse Facilities and Their Role in North Carolina's System of Care, Final Report to the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, October 2001.
[5] Fiscal Research Division, Budget Overview of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, March 2006.

Unlike Medicaid, access to State-funded services is not an entitlement. It is the primary source for indigent care and for services not covered by Medicaid. State funding for services has remained stagnant since 2001. There have been small, isolated budget increases mixed with budget reductions. There have been no inflationary increases. During this same time period, North Carolina's population has increased by an estimated 7%.

Due to changes in federal policy, the service known as Developmental Therapies will no longer be a Medicaid reimbursable service when provided to developmentally disabled individuals. Because of this change, the Division has submitted, and it is the LOC's understanding that the Governor's Budget will include, a request for $30,000,000 in recurring funds to cover the service. While the LOC does not oppose this request, if funded, it will have the effect of further exacerbating the disparity between the State expenditures for disability groups.

Most of the State appropriations are divided into disability and age categories, and the units of local government that administer and manage the MH/DD/SA system (LMEs) are restricted from shifting funds between disabilities. LMEs report having difficulty spending down certain funds, especially related to substance abuse services.

There is no equitable or rational allocation of State funds between LMEs. Excluding Cross Area Service Program funding, the highest SFY 2005-2006 State Service Dollar allocation per capita of catchment area is $48.18, and the lowest is $21.80. The State allocation per capita is $34.15. The median State service dollar per capita is $37.65. Although the reform legislation of 2001 recognized the need to address this situation, to date, neither the LOC nor the Division have developed any recommendations.

Recommendations

1.1. Appropriate $73,452,140 (recurring) to be used for state-funded services. These funds shall be allocated as follows:

a. $30,000,000 for Development Therapy services for the developmentally disabled. The Division shall adopt rigorous care management requirements for this service.

b. $21,726,070 to be used for State funded mental health services.

c. $21,726,070 to be used for State funded substance abuse services.

d. The funds allocated under subsections b. and c. of this section shall be allocated to those LMEs whose current state service dollar allocation per capita is less than the median State service dollar per capita allocation ($37.65) based on the SFY 05-06 allocations.

1.2. Notwithstanding the Executive Budget Act, allow LMEs the flexibility to shift up to 15% of their funds between age and disability categories. All shifts would have to be consistent with any State or federal requirements as to use or "spend down" and LMEs would have to demonstrate how they have addressed the service needs for the funding categories from which funds are being shifted.

2. Building Community Capacity/Financing Reform

Findings:

In 1999, the United State Supreme Court held in Olmstead v. L.C. and E.W. that states have an obligation to provide community-based treatment for persons with mental disabilities. In 2001, the General Assembly created the Mental Health Trust Fund (Trust Fund, G.S. 143-15.3D) and appropriated $50 million to it. In that same year, the Governor used his emergency powers to transfer $37.5 million from the Trust Fund due to the budget crisis. Although the General Assembly has appropriated over $30 million to the Trust Fund since 2001, those amounts have not been sufficient to replace what was lost and have not been sufficient to successfully implement system reform.

The LOC recognizes that affordable and appropriate housing is a critical element of a community's capacity to successfully transition MH/DD/SAS consumers from institutions to the community. There are not sufficient affordable and appropriate housing resources for MH/DD/SAS consumers in this State and that situation significantly impedes the State's ability to comply with Olmstead.

G.S. 143-15.3D(b) provides that the purposes for which the funds in the Trust Fund may be used are:

(1) Start-up and operating support for cost-effective community treatment alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.

(3) Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate and safe services for clients.

(4) Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings.

(5) Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.

The 2001, 2003, and 2005 budgets provide that recurring savings realized from downsizing of the of State psychiatric hospitals would be retained by DHHS for implementation of the hospital downsizing and to support the recurring costs of additional community-based placements. In 2003, the General Assembly passed the Psychiatric Hospital Financing Act (S.L. 2003-314). It provided that the new psychiatric hospital would be financed through certificates of participation. It also amended the Mental Health Trust Fund to provide that recurring savings realized from the closure of any State psychiatric hospitals would not revert to the General Fund but would be used for the payment of debt service for the construction of a new State psychiatric hospital. Any remainder not needed for the debt service was to be credited to the Department of Health and Human Services to be used only for compliance with the Olmstead decision and to facilitate mental health reform. The provisions regarding the use of recurring savings from hospital downsizing contained in the 2005 Budget and in the Psychiatric Hospital Financing Act appear to be inconsistent.

Downsizing of the State psychiatric hospitals has slowed substantially in the last few years due to the lack of community capacity to successfully place MH/DD/SAS consumers in the community. The estimated debt service on new psychiatric hospital for State fiscal year 2006-2007 will be $8,980,551. To date, the Division has realized $3.4 million dollars in recurring savings from downsizing the Dorothea Dix and John Umstead psychiatric hospitals that can be used to offset the projected debt service in FY 06-07 and thereafter. There are not sufficient savings being realized from downsizing to meet fully the debt service cost, and there are no excess funds to shift to community programs.

The apparent inconsistency regarding the use of recurring savings from downsizing combined with the delay in realized savings from downsizing impedes the State's ability to comply with Olmstead and implement system reform.

According to a collaborative project published by the North Carolina Health Education Centers (NC AHEC), the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, and the Cecil G. Sheps Center for Health Service Research, UNC-CH,[6] North Carolina ranks 20th in the nation in psychiatrists per 10,000 population but due to the state's rapid populations increases, that situation is expected to worsen in the coming years. In addition, forty-four counties have a shortage of general psychiatrists, and 43 counties have no child psychiatrists. Also, due to the slow growth in the supply of psychiatrists, public mental health provider groups and especially rural provider groups face stiff competition in recruiting and retaining psychiatrists to their practices. According to a report published by the National Conference of State Legislators[7] almost one in five children in the U.S. has a diagnosable mental disorder, but only about 20 to 25% of those children receive treatment. The gap in treatment is attributed in part to the lack of child and adolescent psychiatrists. Some states are addressing these issues by expanding the used of telemedicine practices to serve children in rural areas. Congress is considering establishing education incentives to recruit child psychiatry residency programs with and estimated cost of $45 million for FY 2006 to 2007.[8]

Recommendations

2.1. Direct the Department of Health and Human Services and the North Carolina Housing Finance Agency to work together to finance 400 independent- and supportive-living apartments for individuals with disabilities.

a. Appropriate $12,050,830 (non-recurring) to provide an operating cost subsidy for the apartments for 10 years to keep the apartments affordable to individuals with income at the SSI-level.

b. Appropriate $11,250,000 (non-recurring) to the North Carolina Housing Trust fund to finance the apartments.

[6] "The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform, January 2006.

[7] "Child Psychiatrist Shortage Looms", Michelle Herman, March 2006.

[8] The Child Health Care Crisis Relief Act (H.R. 1106/S 537).

2.2. Appropriate $20,000,000 (non-recurring) to the Mental Health Trust Fund to build community capacity.

2.3. Appropriate $5,580,551 (recurring) for hospital debt service and reconcile the provisions of the Psychiatric Hospital Financing Act and the 2005 Budget so that debt service is paid from appropriations and savings from downsizing are used for building community capacity.

2.4. Appropriate $1 million (recurring) to AHEC/Rural Health Program to develop a program, which may include loan repayment, to recruit psychiatrists to rural and underserved areas to provide community services.

3. Facility-based and Non-Facility based Crisis Services

Findings:

G.S. 122C-2 provides that, within available resources, State and local government shall ensure that certain "core services", including emergency services, are available to all persons in this State. G.S. 122C- 115.2(b)(1)h. requires area authorities and county programs to develop a business plan that ensures access to core services, including crisis services. G.S. 122C-117(a)(14) provides that crisis services do not require prior authorization, shall be designed for prevention, intervention and resolution, do not consist solely of triage and transfer, and shall be provided in the least restrictive setting possible consistent with individual and family needs and community safety.

Appropriate crisis services are not consistently available across the State. There are not a sufficient number of community hospital psychiatric beds to meet local needs. At least three catchment areas have no community hospital psychiatric beds available. At least four catchment areas have no facility-based crisis services available, and those facilities that are available frequently serve limited populations. Certain crisis services, especially those that are facility-based, must serve large regions in order to be cost effective.

Area authorities and county programs do not have sufficient "start-up" funds to develop and establish new crisis services. There are inadequate State funds to pay for crisis services to the non-Medicaid eligible population.

Certain crisis services must be available at all times regardless of whether the service is being utilized at any particular time. However, the fee for service structure makes it difficult for area authorities and county programs to ensure that necessary professionals will be accessible at all times. It is not clear whether the approved rate for psychiatrists will be sufficient to assure that those services will be available on a continuous basis.

Recommendations:

3.1. Appropriate $10,500,000 (non-recurring) to be used by LMEs to establish a continuum of crisis facilities regionally and crisis services locally. Appropriate $425,000 (non-recurring) for the General Assembly to hire a consultant to assist LMEs with developing and implementing start-up crisis services.

Organize LMEs into 21 crisis regions based upon the existing Geriatric Specialty team configurations or other approved regions. Allocate funds to LMEs on a per capita basis. The funds may be used for operational start-up, capital, or subsidies related to developing a continuum of crisis services. No more than 3% could be spent for administrative costs. Funds not expended during the 2006-2007 fiscal year shall not revert.

LMEs within a crisis region will be required to work together to identify gaps in their ability to provide a continuum of crisis services for all consumers and use the funds appropriated to them to develop and implement a plan to address those needs. At a minimum, the plan must address the development over time of the following components: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite/residential services, crisis stabilization units, 23-hour beds,

facility-based crisis, in-patient crisis and transportation. Options for voluntary admissions to a secured facility would include at least one service appropriate to address MH, DD, and SA needs of adults and MH, DD, and SA needs of children. Options for involuntary commitment to a secured facility would include at least one option in addition to admission to a State facility.

If all LMEs in a crisis region determine that a facility-based crisis center is needed and sustainable on a long term basis, the crisis region shall attempt to secure those services through a community hospital or other community facility first. If all the LMEs in the crisis region determine the regional needs are being met, the LMEs may use the funds to meet local crisis service needs.

Each LME and each crisis region will be required to utilize the technical assistance of a consultant under contract with the General Assembly to develop and implement the plan. The consultant shall assist LMEs and crisis regions to identify local and regional gaps in crisis services, identify options for providing services, implement new services, and maintain transparency and accountability for the use of funds. The crisis region or LMEs shall submit the plan to the consultant and to the Division for review and public comment. The crisis regions and LMEs shall consider the comments prior to submitting a final plan for implementation. Upon submission of a final plan, each crisis region and LME will receive implementation funds.

LMEs and crisis regions must report monthly to the consultant and to the Division regarding the use of the funds, whether there has been a reduction in the use of State psychiatric hospitals for acute admissions, and remaining gaps in crisis services. The consultant shall report regularly to the General Assembly and the LOC regarding each crisis region's and LME's proposed and actual use of the funds.

3.2. Appropriate $9,000,000 (recurring) to create a fund to be used by LMEs to pay for non-Medicaid reimbursable crisis (core) services.

Funds would be allocated to LMEs on a per capita basis. LMEs would bill the fund to pay for crisis services that are provided to non-Medicaid eligible adults and children who have no other 3rd party source of payment and are indigent.

3.3. Appropriate $9,000,000 (recurring) for LMEs to ensure access to core psychiatrist services.

Allocate on a per capita basis. Allow LMEs to use on a non-UCR basis (not fee for service) to maintain access to psychiatric services.

3.4. As recommended by the Division, extend the sunset for the First Commitment Pilot Program from July 1, 2006 to Oct. 1, 2007.

S.L. 2003-178, HB 883 authorized the Secretary to permit up to five, phase one LMEs to substitute for a physician or eligible psychologist, a licensed clinical social worker (LCSW), a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examination of individuals in involuntary commitment proceedings. In order to obtain this waiver, the LME must include it in its business plan and the Secretary must approve.

4. Department of Health and Human Services/Division of MH/DD/SAS

Findings:

In 2001, the General Assembly directed the Secretary of DHHS and the Division of MH/DD/SAS to undertake administering massive system reform. This reform has taken place during a time of budget crisis and changing federal requirements. While recognizing that this undertaking has been extremely challenging that the State has not fully funded the system, and that the task is not finished; in order to be successful, the Secretary and the Division must demonstrate strong leadership and vision in the future.

The State Plan has been reissued each year but has not functioned as the strategic planning document that the General Assembly requested. In particular, it is not clear whether the plans are cumulative or supersede each other, which tasks have been accomplished and which are left to be done, and whether system reform is improving services to consumers.

The Secretary has failed to adopt rules as directed under G.S. 122C-112.1, failed to utilize her authority when approving business plans to move area authorities and county programs towards greater administrative efficiencies, and has implemented policy in a manner that produced distrust among stakeholders and threatened to further destabilize a fragile system.

The Division has allowed the time-lines for State and local implementation to become disconnected, has failed to provide sufficient technical assistance to LMEs, and has been reluctant to impose "State-wideness" in situations where uniform standards have been necessary.

Recommendations:

4.1. Direct DHHS to review the 2001, 2002, 2003, 2004, 2005, and draft 2006 State Plans and:

a. Produce a single document that meets the requirements of G.S 122C-102 and contains a cumulative statement of all still-applicable provisions of those plans.

b. Identify those directives contained in the Plan and other communications by the Division that must be adopted as an administrative rule in order to be enforceable and undertake to adopt those rules.

4.2. Amend G.S. 122C-102 to clarify that the State Plan:

a. Is a strategic document intended to provide a course of State and local action for a 3-year period of time.

b. Shall contain specific goals for system reform, designate benchmarks for reaching those goals and identify data that can be utilized to measure progress towards those goals. The information shall be organized into domains that measure access to services, consumer focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system

efficiency and effectiveness, and prevention and early intervention. The information collected shall be organized in a manner that is simple to read and understand.

c. Is coordinated with the implementation of crisis services by LMEs.

4.3. Amend G.S. 122C-112.1 to clarify that the Secretary and the Division of MH/DD/SAS have a duty to provide more technical assistance to LMEs and must report annually to the LOC and the General Assembly on the progress of system reform.

4.4. Appropriate $1,700,000 to DHHS (non-recurring) to hire one or more consultants to:

a. Assist the Department with the strategic planning necessary to develop the revised State Plan.

b. Study and make recommendations to increase the capacity of DHHS to implement system reform successfully and in a manner that maintains strong management functions by LMEs at the local level.

c. Assist the Division to work with LMEs to:

1. Develop and implement 5-10 critical performance indicators to be used to hold LMEs accountable for managing the MH/DD/SA system. The performance system shall be ready for implementation no later than 6 months after the consultant's contract is awarded and in no event later than July 1, 2007.

2. Standardize the utilization management functions for non-Medicaid services.

3. Develop LME expertise to undertake utilization management for Medicaid services no later than July 1, 2009.

4. Develop a standardized LME operating procedure.

5. Implement other LME management functions.

d. Provide technical assistance and oversight to providers and LMEs to ensure that best practices and new services are being delivered with fidelity to the model.

5. Local Management Entities (LMEs)

Findings:

The role of local MH/DD/SAS programs changed significantly under system reform from that of a service provider to a manager of services. As a result, local programs may only provide services if they receive a waiver from the Secretary. The managerial powers and duties of local programs are not as clearly defined and must be inferred from the statutory requirements of the local business plan.

The responsibility of LMEs to conduct utilization review (UR) for Medicaid services is not clearly articulated in Chapter 122C. It appears that LMEs were expected to develop that capacity because the LME cost model includes funding for this function, the Division solicited applications from LMEs to receive approval to implement that function, and the 2005 RFP for a State-wide Medicaid UR vender provided that between 2 and 6 LMEs were expected to receive authorization to conduct UR during the contract period. Despite these expectations, the Secretary has determined that all Medicaid UR will be conducted by a State-wide vendor for at least the next three years. While the LOC recognizes the Secretary's obligation under Medicaid to ensure "State-wideness", it finds that the process she undertook to implement this significantly undermined the stability of the public system. The LOC also finds that by removing this function from the public sector, the Secretary may significantly undermine the ability of LMEs to manage services in their catchment areas. In light of these changes, the LOC finds that utilization review for State-funded services and screening, triage and referral of all crisis calls are necessary components to the management role of local programs.

In 2001, the General Assembly directed the Secretary to develop a plan to accomplish the consolidation of area authorities so that by January 1, 2007, there would be 20 total programs. While Chapter 122C does specifically mandate consolidation, the General Assembly's intent was clear. The Secretary did not utilize her statutory authority to achieve consolidation through the approval of local business plans and there are currently 29 LMEs. According to the Secretary's report to the General Assembly, there are very few additional mergers to be realized. The LOC finds that additional consolidations are necessary to accomplish system reform.

In 2001, the General Assembly recognized that competent management was critical to the success of system reform. It amended G.S. 122C-121(d) to provide that area programs directors must have a master's degree, and have related and managerial experience. The LOC finds that the success of an area program is largely dependent upon the ability of the director to understand and implement system reform. It also finds that the current statutory qualifications are drawn very broadly and may not capture the necessary skills. The LOC also finds that the position of LME finance officer is critical to sound fiscal management, but there are no statutory requirements for that position.

G.S. 122C-119.1 requires all area board members to "receive initial orientation" on their responsibilities. It also requires DHHS to provide training in "fiscal management, budget development, and fiscal accountability". The LOC finds that it is critical that board members receive this training and that there should be some mechanism to enforce this requirement.

Recommendations:

5.1. Amend Article 4 of Chapter 122C to clearly articulate those administrative and managerial functions that are the responsibility of an LME. These shall include: utilization review for services not billed to Medicaid, all screening, triage and referral; customer service; provider development, monitoring and endorsement; quality assurance and improvement, authorization of State hospital bed days, CAP-MR/DD authorization and management, and review and approval of all person centered plans. Clarify that LME functions may not be removed by the Secretary absent an individualized finding that a particular program is not providing minimally adequate services or is in imminent danger of failing financially.

5.2. Direct the Division to recalculate the LME systems management allocations for SFY 2006-2007 to include funds for each LME to implement 24/7/365 screening, triage and referral and the review and approval of all person centered plans. This recalculation represents $4,327,089 in State and Medicaid funds to be used by LMEs to implement these functions.

5.3 Direct the Department to retain all funds withdrawn from the LME cost model allocations that are not accounted for in subsection 5.2 of this section (approximately $11,000,000) and transfer the funds to State-funded MH/DD/SA services to be allocated on a per capita basis to all LMEs and evenly divided between all age and disability categories.

5.4. Amend Article 4 of Chapter 122C to comply with the current Division practice to require that by July 1, 2007, all LMEs must have catchment areas that include at least 6 counties or a population of at least 200,000. LMEs that do not comply with this requirement will lose 10% of their administrative funding each year until mergers have been accomplished. Administrative savings realized under this provision shall be reallocated to state-funded MH/DD/SA services and allocated state-wide on a per capita basis.

5.5. Direct the Office of State Personnel to study the job functions for area directors and finance officers and implement job classifications by December 1, 2006, that reflect the necessary skills for those positions.

5.6. Amend G.S. 122C-119.1 to specify that board members must receive at least 6 hours of training annually. The Secretary shall monitor compliance with this requirement and shall remove LME board members who do not comply. The Division, the Council of Community Programs, the Association of County Commissioners, and the School of Government at UNC-CH shall develop and deliver the programs. Appropriate $20,000 (recurring) to the current training contract to implement.

5.7. Standardize area board membership to 3-year terms and prohibit individuals from serving more than 2 consecutive terms. Current members would be allowed serve no more than 3 years beyond July 1, 2006. Amend

LME board member requirements to increase participation by individuals with business and financial backgrounds and to create more flexibility as to the appointment of consumer members.

5.8 Amend Chapters 122C and 160A to require that the quarterly financial reports filed by LMEs with their counties must be reviewed and approved by the county finance officers.

6. Consumers

Findings

In 2001, the General Assembly recognized the importance of consumers in system reform. It directed that the State Plan provide for "consumer involvement in planning and management of system services." The State Plan directed that each LME establish a local Consumer and Family Advisory Committee (CFAC) and charged the CFACs with participating in and commenting on the LMEs business plans and operating budgets. The State Plan also created the State CFAC, whose members are appointed by the Secretary.

The LOC finds that it is important to focus and formalize the advisory role of consumers in system reform. It also finds that representation on the State CFAC should be broadened to include appointments by other stakeholders.

Recommendations:

6.1. Codify local CFACS. Clarify and focus their roles and responsibilities. Specify the staff assistance that LMEs must provide to them.

6.2. Codify the State CFAC. Provide that of the 21 members, 9 shall be appointed by the Secretary, 3 by the President Pro Tempore, 3 by the Speaker of the House of Representatives, 3 by the Council of Community Programs and 3 by the Association of County Commissioners. The Secretary shall appoint members who represent each disability group served by the system and also appoint members who represent the interests of children and severely developmentally disabled adults. The President Pro Tempore, the Speaker of the House, the Council of Community Programs and the North Carolina Association of County Commissioners shall each appoint one person from each of the three State regions for institutional services (Eastern Region, Central Region and Western Region).

6.3. Appropriate $1,200,000 (recurring) to implement the MH/DD/SA Consumer Advocacy Program (Article 1A of Chapter 122C) as enacted in 2001.

7. Providers

Findings

Providers are one of the major components in system reform and service delivery. The success of reform depends in large part upon a provider system in which high quality services are available in sufficient quantity to meet the identified needs of consumers. However, at the same time that the public system has needed more and better providers to deliver services, a variety of circumstances have made it very difficult for both established and newly created providers to survive financially.

LMEs have adopted differing provider contracts and required differing levels of utilization control. There has not been a uniform definition of what constitutes a *clean claim*, resulting in confusion in what is required for billing and delays in payments. Providers also report excessive and unnecessary paperwork in order to obtain authorization to provide services.

System reform also requires providers to implement new services based upon evidence based-practices. Utilization of these best practices will result in better services to consumers, and will be a better use of public funds because the services have been shown to be more effective.

The Division has developed a Provider Action Agenda to address many of these issues. The authority of the Division to implement uniform processes and procedures should be clarified.

Recommendations:

7.1. As recommended by the Division, amend G.S. 122C-3(14)b. to make the facility licensure requirements for outpatient substance abuse services consistent with the facility licensure requirements for outpatient mental health or developmental disability services.

7.2. Direct the Division to adopt:

a. A uniform provider contract, uniform billing and claims forms, and uniform person centered plan forms to be used by all providers and all LMEs.

b. A standard definition of what constitutes a clean claim, standardized denial codes, a standardized policy related to the coordination of benefits.

c. A system to provide timely outcome data to LMEs.

7.3. Direct the Division to identify other areas of standardization that could be implemented without undermining the management authority of LMEs.

7.4. Direct the Division to identify and eliminate processes and procedures that are duplicative or result in unnecessary paperwork and eliminate or reduce those as much as possible.

8. Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Findings:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services was created in 2000 to develop a plan for reform of the MH/DD/SA system. The committee and its multiple subcommittees met repeatedly during the interim and into the Regular Session of the 2001 General Assembly. The resulting legislation (HB 381, S.L. 2001-437) significantly restructured the system and put in place the framework of reform. The foundations of reform include: local management of the system, decreased reliance on State institutions, community based best practice treatments, increased consumer involvement, access to multiple and qualified providers, and performance and fiscal accountability to the State and local governments.

The LOC is charged with examining on a continuing basis system-wide issues affecting the development, financing, administration, and delivery of MH/DD/SA services. It is also charged with studying the budget, programs, administrative organization, and policies of DHHS to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided in North Carolina. In this capacity, the LOC has replaced the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) as the legislative entity monitoring the MH/DD/SA system. All reports previously submitted to the Commission now come to the LOC, and the Commission has been inactive since passage of the reform legislation.

Recommendations:

8.1 The LOC shall study the following issues and report its findings and recommendations to the Regular Session of the 2007 General Assembly:

a. Mechanisms to allow LMEs to purchase bed days from the State psychiatric hospitals. The LOC shall consider options for holding LMEs accountable for their use of State psychiatric institutions, provide incentives to increase community capacity, and options for ensuring the State institutions have a sufficient funding stream to ensure quality care to patients and a stable and well qualified workforce.

b. Whether implementation of a Medicaid 1915(b) waiver on a State-wide or expanded basis would strengthen the ability of LMEs to manage the MH/DD/SA system. As part of the study, the LOC shall examine the impact of the waiver upon the ability of Piedmont Behavioral Health's to implement LME management functions including utilization management, consumer satisfaction, provider monitoring, use of best practices, and any other matters the LOC determines are relevant. If the LOC determines that a Medicaid 1915(b) would help improve the management capacity of LMEs, it shall also examine whether it would be more appropriate to seek a State-wide waiver, or whether it would be advisable for additional LMEs to seek individual waivers.

8.2. Amend Article 27 of Chapter 120 to make the LOC's oversight powers consistent with those of other oversight committees. In particular, make the provisions of G.S. 120-19.1 through 120-19.4 applicable to the LOC.

8.2 Repeal Article 24 of Chapter 120 (The Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services.)